FINAL Report

Health Transition Fund Project 9605:

First Nations and Inuit Home Care

Health Canada / Santé Canada

PREFACE

Health Canada and First Nations and Inuit identified home and community care as a major health service gap and, in 1998, partnered on a proposal to the Health Transition Fund for a Home Care Pilot Project. Five pilot sites encompassing eight First Nations communities of geographical and cultural diversity participated.

During the same period, Health Canada was working in collaboration with First Nations and Inuit and the Department of Indian Affairs and Northern Development on the development of a Home Care Framework – the first phase of an overall Continuing Care Framework.

The framework development and the Health Transition Fund Project led to a 1999 Health Canada comprehensive Home and Community Care Program for First Nations and Inuit. An investment of $152 million over three years with $90 million ongoing was made.

With programs now underway in the five Project sites, Health Canada in collaboration with First Nations and Inuit expect to have home and community care programs in over 600 First Nations and Inuit communities by the end of 2001/2002. This ambitious and challenging task is being achieved in large part due to the overwhelming success of the Project in identifying key planning tools and guidelines needed to support the development of a successful program, and in sharing the critical "lessons learned" that have influenced many of the management decisions made to date. It goes without saying that the roll out of the National Home and Community Care Program would not be at the stage of development and implementation that it is today without the benefit of this Project.

The Project Steering Committee would like to thank the pilot sites for the significant role they played in laying the foundation for the National First Nations and Inuit Home and Community Care Program, and acknowledge the Health Transition Fund for recognizing the importance of this Project in improving the Canadian health system.

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EXECUTIVE SUMMARY

This report summarizes information collected during the Health Transition Fund Project on First Nations and Inuit Home Care.

The Project was carried out over an 18 month period in five sites encompassing eight First Nations communities of geographical and cultural diversity. The expected outcomes of the Project were to:

- confirm the need for home care services within First Nations and Inuit communities;
- confirm the validity of the National First Nations and Inuit Home Care Framework;
- test options which facilitate the integration and coordination of home care services with other services at the federal, provincial and community level;
- provide direction and guidance to other First Nations and Inuit communities in terms of the applicability of the models developed.

Through the Project, the pilot sites confirmed the need for a comprehensive and integrated home care program for First Nations. High levels of chronic illness, disabilities, lifestyle diseases and poor health status generally were found, together with an increasing population in general and an increasing Elders population in particular.

All five sites identified the need to develop a strong foundation of essential services to meet the needs identified through the community needs assessment, and, where home care services existed, to improve and/or expand these services.

The essential services proposed in the National Framework on First Nations and Inuit Home Care were validated by the sites. The sites strongly agreed that a comprehensive home care program is needed which can provide client assessment, program and case management, home support, personal care, home care nursing, in-home respite, appropriate medical supplies and equipment, records and information management and linkages to other health and social services. The program models outlined in Appendix A and developed through the Project describe how the essential services are being met.

Through the Project, four of the five sites integrated the funding for the Department of Indian Affairs and Northern Development's Adult Care Program (In-Home Component) with the Home Care Program. The integration of program management and supervision, however, was accomplished in all five sites. The integration options tested during the Project are described in the program models outlined in Appendix A.

The findings in the models used by the pilot sites were found to be extremely applicable to other First Nations and Inuit communities. As a result of the interim Project findings, Health Canada in collaboration with First Nations and Inuit made a significant investment in the development of a Planning Resource Kit to assist First Nations and Inuit in the planning and development of their home and community care program. The resource kit is based on the tools and guidelines developed and tested through the Project and builds on the "lessons learned". The "lessons learned" from the Project have also influenced many of the management decisions made to date in the development and roll out of the National First Nations and Inuit Home and Community Care Program.

In conclusion, the Health Transition Fund Project on First Nations and Inuit Home Care has confirmed the need for new, improved, and/or expanded home care services using as the foundation the essential services identified in the National Home Care Framework. The Project has resulted in a great deal of insightful, practical and valuable information that has provided guidance to Health Canada, and First Nations and Inuit in the development and roll out of the National First Nations and Inuit Home and Community Care Program.

INTRODUCTION

The Health Transition Fund was established by Health Canada in 1997 in response to a national review of health services. The Fund supports approaches to health systems in four priority areas: home care, integrated service delivery, pharmaceutical issues, and primary care.

Health Canada partnered with First Nations and Inuit on a proposal to the Health Transition Fund for a Home Care Pilot Project. The Project, initiated in the Fall of 1998, was carried out under the direction of the First Nations and Inuit Health Branch (formerly named the Medical Services Branch), Health Canada and overseen by a Project Steering Committee comprised of federal, provincial and First Nations representatives.

The final evaluation report for the Project provides insight and information on lessons learned, and passes on the advice and words of wisdom from the community leadership and individuals involved in the Project.

Five program models will be discussed in terms of the extent to which they demonstrate the need for home care services within First Nations and Inuit communities, and the extent to which they validate the National Home Care Framework. The common experiences, challenges and successes of the five participating pilot sites will also be explored in terms of their relevance to other communities. The guidance shared by the five pilot sites is based on real community level grass roots experiences.

The pilot sites hope the report will serve as a tool for other First Nations and Inuit communities who are planning and developing home and community care programs.

> *"For the pilot sites we are slowly finding our way through each issue and at the time we may feel we are accomplishing little but ultimately we hope we are building bridges for those who come after."*
>
> Project Nurse Coordinator
> Eel River Bar First Nation

Home Care Coordinators - Kingfisher Lake, Wapakeka, Shibogama First Nations Council Health Authority, Wunnumin Lake.

Overview of the Pilot Project (How the Project was Designed)

Objectives

The following objectives were established for the Project:

- to generate evidence and measure the impact of change in health practices which have resulted in an escalation in the need for First Nations and Inuit home care services;
- to provide evidence of the necessary program elements and infrastructure requirements to be considered in future program design and implementation of a First Nations and Inuit Home Care Program;
- to maximize services through better integration and coordination with the Department of Indian Affairs and Northern Development's Adult Care Program (In-Home Component);
- to validate the First Nations and Inuit Home Care Framework through the Project.

Chief and Council and Home Care Team, Eel River Bar First Nation; Project Evaluation Team Members

Five sites participated in the Project from different regions across Canada and were selected for their diversity in terms of culture, geography, governance structure and degree of isolation.

The five pilot sites were:

- Champagne and Aishihik First Nations (Southern Tuchone; Yukon Territory; 834 members in core communities; rural semi-isolated);
- Little Red River Cree Nation (participating communities of Jean D'Or and Garden River; Cree; Northern Alberta; 1072 combined on-reserve members; semi and remote isolated);
- Long Plain First Nation (Plains Ojibway; Southern Manitoba; 1108 on-reserve members; rural non-isolated);
- Shibogama First Nations Council Health Authority (participating communities of Wapakeka, Wunnumin Lake, Kingfisher Lake; Oji Cree; Northwestern Ontario; 1042 combined on-reserve members; isolated fly-in):
- Eel River Bar First Nation (Micmac; New Brunswick; 393 on-reserve members; rural non-isolated).

The sites were notified of their selection for the Project in October 1998 and the evaluation took place in May 2000.

Over the 18 months of the Project, the pilot sites were required to accomplish several tasks in order to meet the objectives of the Project:

- carry out a Community Needs Assessment using a number of standardized assessment tools;
- develop a Service Delivery Plan for home and community care services. For this phase of the Project, a Peer Review process was established to measure the service delivery plans against established criteria by a team of peers. The goal of the peer review process was to ensure:
  - that all essential service elements were included in the plan,
  - that the management structure was in place to support a safe and effective program,
  - that the foundational structure could support future programming within the contiuum of care, and
  - that the resources available, both existing and new, were planned for in an effecient and effective manner;
- develop the necessary infrastructure for the delivery of home care services (e.g. management structure, staffing, supplies and equipment);
- implement the home care services identified in the Service Delivery Plan;
- provide the required documentation to the Project Manager; and
- participate in the Project evaluation.

It was necessary to build in supportive mechanisms to assist the sites to accomplish these tasks within the fairly restricted time limitations. A Project Manager at the First Nations and Inuit Health Branch provided direction and maintained linkages between the Project and the Project Steering Committee. A consultant was contracted to support the communities through the development of written documents and templates and to provide home care expertise. Throughout the Project, a number of meetings and teleconferences were arranged to facilitate communication and information sharing between the pilot sites.

The Home Care Pilot Project was expected to answer the following questions as posed in the Project Charter[1]:

Does the evidence generated as a result of the Project confirm the need for the development of a First Nations and Inuit Home Care Program?

What are the significant areas of need as indicated by the community needs assessment?

How do First Nations and Inuit models for pilots respond to the identified needs?

Is the National First Nations and Inuit Home Care Framework validated through the Project?

How do the models used in the Project contribute or facilitate to the integration and coordination of First Nations and Inuit home care services with other services?

How applicable are the findings in the models used in the pilot sites to other First Nations and Inuit populations, and what are their implication for future health programming in home care?

[1] The Project Charter guided the common undertaking of the Project by outlining the Project's purpose, objectives, how the Project would be carried out, and the roles/responsibilities of key Project stakeholders.

Evaluation Methodology
(How the Information was Gathered)

The evaluation of the Project utilized a combination of both qualitative and quantitative data collection methods. Reporting tools were developed to collect information throughout the Project which were sent to both the First Nations and Inuit Health Branch and the First Nations leadership of the participating sites. The information for the final evaluation was collected through a variety of methods which included:

- verbal input from pilot site coordinators (or Home Care Coordinators) and health and social services team members;
- the Community Needs Assessment Reports;
- midpoint evaluation reports and interviews which were used in the "Lessons Learned" presentation at the National Home Care Conference, December 1999;
- monthly reports to describe the work being accomplished, including a summary report and a statistical report of services provided;
- a final written self-assessment completed by each pilot site team designed to identify the accomplishments to date and assist in plans for future program improvement; and
- a site visit conducted by a peer team to interview leadership, clients and the project team in order to validate the self-assessment of the home care services development in each community.

EVALUATION FINDINGS
(WHAT WE HAVE LEARNED)

The Need for First Nations and Inuit Home Care

The first task of the five sites was to compile a community needs assessment to identify their home care needs by looking at the community demographics and the major health issues and defining the gaps between existing services and the identified needs. Through this process, the pilots sites confirmed the need for a comprehensive integrated home care program for First Nations. High levels of chronic illness, disabilities, lifestyle diseases and poor health status generally were found, together with an increasing population in general and an increasing Elders population in particular.

All five sites identified the need to develop a strong foundation of essential services to meet the needs identified through the community needs assessments and to improve and/or expand home care services where they existed.

Four of the five pilot sites identified the need for a formal client assessment process, community capacity to manage home care services, and for pre-service and in-service training. Three of the five communities identified the need for meal services, improved linkages with off-reserve health care systems, especially in the area of discharge planning, for home nursing services to be initiated or expanded, and for improvement or expansion of home support[2] services.

Several other needs were identified by one or two sites. These included personal care, respite, rehabilitation services, mental health, adult day programs, dietitian services and transportation.

[2] Home Support is a generic term used to describe services which support independence in the home by assisting with managing household tasks and personal care services.

All five sites have planned and implemented services based on their unique needs as identified in their community needs assessment. Most sites are still in the implementation stage and are planning further development or expansion of their services. All communities implemented:

- a formal client assessment process
- managed care (case management and referral and linkages)
- in-home respite care
- in-home meal services
- improved structure and coordination of home support services
- a program management structure
- integration of the program management of the Adult Care Program (In-Home Component) with the Home Care Pilot Project
- training of the home care workers.

A detailed description of each pilot site program model is outlined in Appendix A.

Team members,
Eel River Bar
First Nation

Validity of the National First Nations and Inuit Home Care Framework

The Project confirmed the efficacy of the "essential core elements" proposed by the National Framework on Continuing Care Phase 1 - First Nations and Inuit Home Care. A comprehensive Home Care program is needed which can provide a foundation of basic services in the areas of client assessment, homemaking, personal care and home care nursing, and which has the ability to provide community-based management, coordination and monitoring.

The pilot sites were generally in agreement that these core elements were essential for the foundation of the home care program. This view is captured by the following quote from one of the pilot coordinators:

> *"The home care needs in our community do reflect the national framework that has been developed. There is a definite need for service to be based on **assessed** need rather than want. There needs to be more accountability in providing **skilled** service to clients via trained staff. Care needs to be **coordinated**, and the **linkages** with other agencies both on and off reserve is vital to this."*
>
> Home Care Coordinator - Eel River Bar First Nation

All of the essential elements identified in the National Framework are in place in all five sites, although the home care nursing service is not provided through the Project in two of the sites (see Table 1). The Province of New Brunswick's Extramural Hospital Program provides home care nursing services to New Brunswick First Nations communities, and the Shibogama First Nations Council Health Authority has two full time nursing station nurses in their communities who for now provide home nursing services.

TABLE 1

Development of Home Care Essential Service Elements in Pilot Sites

Home Care Essential Service Elements	In Place Before Project	In Place at Evaluation
Structured client assessment process	0	5
Managed care process	0	5
Provision of home care nursing	1	3
Provision of home support services	5	5
In-home meal preparation	3	5
In-home respite	1	5
Linkages to other health and social services	1	5
Availability of medical supplies	Information not available	5
Program management capacity	1	5
Information and data collection	0	5

Once the essential elements were in place, some of the communities utilized their resources to expand the scope of their home care services.

Integration and Coordination of Home Care Services with Adult Care Program (In-Home Component)

Four of the five pilot sites integrated the funding from the Department of Indian Affairs and Northern Development's Adult Care Program (In-Home Component) with the Home Care Program. The financial integration did not occur in Ontario due to current legislation and the complexity of the funding arrangement between the Department of Indian Affairs and Northern Development and the Government of Ontario. The integration of program management and supervision however was accomplished in all five sites.

Note: At time of printing, discussions have been initiated between officials from the First Nations and Inuit Health Branch, the Province of Ontario and the Department of Indian Affairs and Northern Development regarding the delivery options for the Adult Care Program and Long Term Care Program currently managed by the Government of Ontario.

The benefits of integration with the Adult Care Program (In-Home Component) were confirmed throughout the Project evaluation. It was reported that the added structure, supervision, training and the move to needs-based allocations of services, which resulted from the pilot home care services, enhanced the professionalism of the services and improved the self-esteem of the home support workers. The clients reported appreciation of the increased quality of care and accountability. The leadership in two communities noted that the improved management of the program has reduced the number of complaints from the community regarding services.

All pilot sites combined the management for the Adult Care Program (In-Home Component) with the new home care program. Under the home care program, all the in-home adult care services provided became based on the assessed health and functional needs of the clients. Professional supervision is provided for personal care, client care is assigned, and staff reports are required. These changes have resulted in many positive developments and successes that were identified during the evaluation. These include:

- increased leadership and community support of services based on assessed needs;
- improvements in the overall quality of care provided;
- increased professionalism of staff - "home care workers don't feel like maids but like health team members";
- improved opportunities for professional supervision of personal care services;
- that all people can receive care if it is needed rather than having eligibility criteria based on age or finances;
- the home care workers are part of the health care team which improves the coordination of community services;
- increased accountability of staff with reporting requirements such as time sheets, and reporting client care provided;
- clients are assessed to determine the things that they and their caregivers cannot provide and care is assigned based on these needs. This results in a better matching of needs and resources. Services are in place for those who need them most.

There are, however, a number of continuing challenges in this area:

- high management requirements to make the program responsive to needs;
- changing policies and practices that have been in place for years;
- the significant amount of time it takes to gather community support for change;
- the difficulty in creating an understanding that home care is only for things that clients cannot do for themselves;
- the transition from past practices of paying family members to provide care to now providing care by trained workers based on client need and family involvement.

Words of Wisdom

It is very challenging to change policies and program habits that have been in place for many years. It must be done slowly and with wisdom, and with the support of

- community leadership
- health and social services (adult care) staff
- the elders

Critical Developmental Issues (The Learning Applied)

The findings in the models used by the pilot sites were found to be extremely applicable to other First Nations and Inuit communities. As a result of the Project findings, Health Canada in collaboration with First Nations and Inuit made a significant investment in the development of a Planning Resource Kit to assist First Nations and Inuit in the planning and development of their home and community care program. The resource kit is based on the tools and guidelines developed and tested through the Project and builds on the "lessons learned". The "lessons learned" from the Project have also influenced many of the management decisions made to date in the development and roll out of the National First Nations and Inuit Home and Community Care Program.

The following highlights some of the key learning from the Project in the areas of:

- communication
- community involvement and support
- supports during planning and development
- supportive infrastructure for program delivery
- time required for planning and development of services
- staffing issues
- training of home care staff
- financial issues.

Communication

The five pilot sites identified the need to develop a common understanding of the concept of "home care". It was found that most community members see it as a homemakers service and it has taken continuous communication and education with community members to build a common understanding of the broader concept of home care. The development of a communication strategy, therefore, is an essential element of planning and implementation of the program. The philosophy of supporting client independence and only doing what the client cannot do for themselves is an essential part of home care which must be supported and understood by community leadership and the health and social service team.

> *"I think the overall key to success is communicating. You can have the greatest home care plan in the whole country but without key support in the community, often the best laid plans fail."*
>
> Home Care Coordinator
> Eel River Bar First Nation

Kingfisher Lake, Ontario

A number of effective approaches to communicating with community members were identified, including:

- use of local radio in the local language
- development of a program pamphlet to introduce program guidelines
- community meetings
- individual contacts
- meetings with Elders
- presentations to community leadership
- monthly newsletters
- workshops to develop sensitivity to issues concerning persons living with disabilities
- video conferencing to connect remote communities with each other and home care expertise
- inter-agency meetings.

A number of challenges were also identified:

- unrealistic expectations of home care services
- the persistent idea that home care is a "maid service"
- the switch to services based on the assessed need
- developing effective communication in communities where English is not spoken by most community members.

Words of Wisdom

COMMUNICATION

Develop a communication strategy to ensure community involvement and understanding of home care so that the new program will be accepted and supported as it develops.

Use a variety of methods to communicate.

POINTS TO CONSIDER

- The program mission or vision is usually part of written materials.
- Newsletters are good means to keep people informed. One coordinator stated that she knew people were reading them when she missed a month and people called in to ask where it was.
- Communication should be done in the local language whenever possible.
- Communication methods and materials should be approved by leadership.
- All communication should be culturally appropriate for the community.

Community Involvement and Support

The need for community and leadership participation and support was identified in every phase of the Project. This participation and support began with community consultation during the community needs assessments and with the development of a planning team. This process was identified as a requirement for successful program development and implementation.

The evaluation found the following approaches to community and leadership participation and support to be particularly effective and successful:

- regular inter-agency meetings
- development of a strong planning team
- commitment and dedication of the team who understand and are committed to the philosophy of care
- leadership support and their belief in the importance of the project
- team work.

> *"Work as a team. Brainstorm and discuss the issues and get input from the people."*
>
> Health Director
> Kingfisher Lake,
> Shibogama First Nations Council

> *"The project has brought the community together. Native and non-Native Elders gathered to eat and discuss home care."*
>
> Health Councillor
> Champagne and Alshihik
> First Nations

However, a number of challenges in this area were also identified by the pilot sites:

- difficulty in finding time with leadership to discuss home care issues;
- work-related demands and pressures make it difficult to get the team together;
- community crisis can necessitate changes in plans;
- staffing changes create challenges;
- unrealistic client and community expectations.

Words of Wisdom

COMMUNITY SUPPORT AND INVOLVEMENT

Use a team approach in planning and implementing the home and community care program.

Consult with the community to receive input into the needs identification and the plan development.

Develop a planning team with representation from key groups.

Report to and receive guidance from leadership.

Planning and Development

Solid and thoughtful program planning was identified by the pilot sites as an essential step to laying the foundation for a successful program. This includes a number of necessary supports to the planning, development and implementation of quality home care services. For example, access to technical support in the form of home care expertise with practical experience in home care planning and delivery, written materials, templates and sample forms, meetings and conference calls, and peer support.

Home Care Expertise

All of the pilot site coordinators identified the need for support and consultation from experts in the home care field. The Home Care Consultant for the Project was often contacted by telephone for support, advice on the planning, implementation and delivery aspects of the Project, and the sharing of materials. Other sources of expert support were found closer to the community. Materials and resources were also accessed from local home care programs. First Nations and Inuit Health Branch regional contacts participated in the Project so that they could provide additional support.

Meetings and Conference Calls

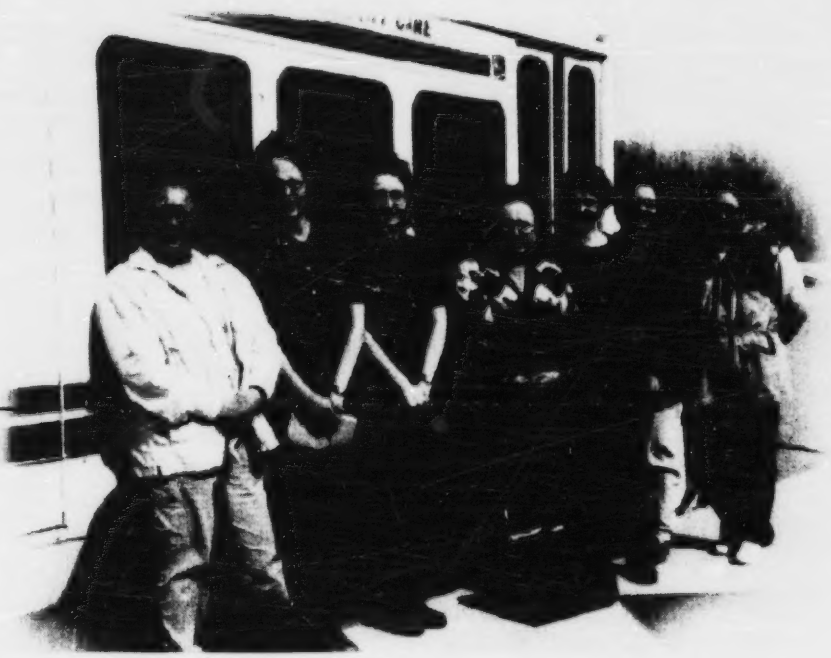
Each community received a visit from the Project Manager to introduce the Project. The pilot sites had two registrations plus travel provided to attend the 1998 and 1999 National Home Care Conferences. Staff from the pilot sites also attended four meetings during the Project. Numerous conference calls were held to share information, make joint decisions and accomplish joint planning tasks.

Peer Support

All pilot site coordinators felt that the opportunities for peer support and interaction made possible by their meetings and teleconferences and informal contacts were extremely important to the success of their individual programs.

Written Materials and Templates

The written materials and templates that were developed for the Project were seen as beneficial in the planning and development of the individual community programs. The materials formed the basis for the Planning Resource Kit developed for the National First Nations and Inuit Home and Community Care Program.



Long Plain First Nation Home Care Management Team and Project Evaluation Team members.

Words of Wisdom

VISION STATEMENT

"Sit down and decide on a mission and philosophy, everything else (the plans and decisions) is driven from that."

Champagne/Aishihik

Take time to lay the foundations of a solid home care program. Start with the Mission Statement and Philosophy which is supported by leadership.

All five of the pilot sites identified the need for the development of a specific Mission or Vision Statement to provide guidance to the program. This statement is best developed in consultation with community members and leadership. It is also essential that the community leadership not only approve the statement but truly understand and support it.

POINTS TO CONSIDER

A statement supporting wellness and independence is usually a foundational piece of a Home Care Mission Statement.

Words of Wisdom

PLANNING AND DEVELOPMENT

"Take it slow....."

(Champagne and Aishihik First Nations)

Establish the infrastructure first including the policies and guidelines, management structure, professional supervision, and the processes such as client assessment charting and time sheets. Services are best implemented after the foundation is in place.

It is also essential to communicate the program information to gain community support for any changes made.

Communities who are planning and developing home and community care programs need the support of written home care materials and guides, expert support in the home care field, and opportunities to meet with peers for shared learning and support.

POINTS TO CONSIDER

- It is important to set time lines and develop a work plan to be efficient and keep on task. This will help keep you on task in spite of the multiple interruptions encountered.

- Be prepared for pressure to deliver services before the planning is complete.

- Good planning at the outset will save time later.

- Without a solid foundation, the walls will crack in time.

Project Evaluation Team meeting, Little Red River Cree Nation.

Supportive Infrastructure for Program Delivery

Successful programs must have supportive structures which guide, strengthen and reinforce the services. The Project demonstrated the need for the following infrastructure:

Program Management:

- support from experts in the home care field
- professional supervision
- pay equity with others in similar positions
- staff benefits such as pension, vacation and sick leave
- liability protection insurance
- scope of practice clearly defined
- personnel policies in place and applied.

Professional Development:

- training so that community-based home care workers can provide personal care, meal services, and palliative care
- regular in-service training for all staff
- foot care certification for Registered Nurses and Licenced Practical Nurses
- CPR and Basic First Aid
- food handling course
- lifts and transfers.

Adult Day/ Congregate Meal Program, Long Plain

Supportive Structures:

- staff report forms
- orientation plan
- job descriptions
- home care policies and procedures
- monthly report forms to track client care
- client charting tools
- client assessment tool
- client care plan.

Equipment and Supplies:

- transportation for home care nurses
- nursing equipment and supplies
- an equipment loan cupboard.

Capital:

- accommodation for home care personnel in northern locations
- computer equipment and software
- office space at each community for home care staff
- desks and office furniture
- handicapped transportation.

The following were identified during the evaluation process as contributing to successful outcomes in this area:

- the sharing of policies, job descriptions and information on infrastructure requirements that occurred between programs;
- support from leadership for the infrastructure developed;
- policies and procedures which enable rapid access to equipment which can enhance the independence of clients;
- employee benefit packages and liability insurance were put in place in most pilot sites.

However, a number of challenges were also identified in this area:

- the development of policies is very time consuming;
- policies must be approved by leadership;
- the high cost of providing staff accommodations in northern communities;
- the substantial number of planning and developmental tasks to be accomplished within a limited time frame.

> *"One cannot expect a good and solid foundation for a program of this magnitude, that was given so little time in between planning and implementation. There is so much ground to cover and so many factors to consider that interrupt the pace of the actual delivery"*
>
> Home Care Licensed
> Practical Nurse
> Little Red River Cree Nation

Words of Wisdom

SUPPORTIVE STRUCTURES

Take time to develop a solid foundation that includes an appropriate management structure, training plans, program and staff policies and supplies and equipment.

Consider the needs of both clients and staff to build a strong base of support.

POINTS TO CONSIDER

- Review the scope of practice of the staff in the program.
- Ensure there is professional supervision.
- Ensure that the program operates within the legal requirements of the province/territory.
- There must be safeguards to ensure that clients receive safe, quality care.

Champagne and Aishihik First Nations Traditional Territory, Yukon

Time Requirements

All pilot sites reported that they needed more time to complete the required planning and development tasks. They felt that the time lines for the Project were too compressed and that expectations regarding the completion of tasks were too high (refer to Table 2 for average timelines to complete planning activities). It was noted that the introduction of the National Home and Community Care Program impacted the operations of other community services. Time is needed to redefine roles and responsibilities with other health and social development staff, to work out new working relationships and to find and/or share equipment and space. This critical learning confirmed the need for a community based and community paced approach to program development.

> *"The program planning was a very time consuming task, but very important as this will set the foundation for the program."*
>
> Home Care Coordinator
> Eel River Bar First Nation

TABLE 2

Average Time Lines

Activity	Time taken
Community Needs Assessment	1440 hours
Service Delivery Plan	544 hours
Implementation Plan and Activities	843 hours
Training Plan/Oversee	470 hours

A number of successes, however, were identified in this area:

- support from community leadership;
- support from community members;
- positive changes have occurred and services have been improved and expanded;
- improved quality of services;
- supportive infrastructure, such as policies and guiding documents and plans, have been developed.

The evaluation of the pilot sites also identified the following challenges regarding the time requirements of developing home care services:

- effecting positive change takes time;
- ***"It is very challenging to change policies and program habits that have been in place for 12 years. It must be done slowly and with wisdom"*** (Eel River Bar First Nation)
- there was difficulty finding time to meet with leadership;
- community events and crises often interfered with plans;
- the workload of planning staff is substantial.

> *"When we first started the original planning taken from the needs assessment (war and peace version), we thought we would be able to give the moon and stars but this past year has proved that if we even have minuscule amounts of moon and star dust, then and only then should we try to deliver."*
>
> Little Red River Cree Nation

Staffing Issues

Staffing issues identified during the Project focussed mainly on three areas: the type and qualifications of staff required to plan and develop a home care program; the supportive structures needed for the staff; and the definition of roles and responsibilities of the new positions and their impact on the roles and responsibilities of existing community health staff.

> *"The Coordinator must be a registered nurse who is capable of doing complete client assessments as well as designating assignments based on client need."*
>
> Long Plain First Nation

With respect to the type of expertise required for the planning and development of community-based home care services, a combination of community expertise and home care expertise was seen as the most effective planning approach. All sites hired registered nurses to develop the home care program. It was felt that a registered nurse with extensive home care experience should be teamed with a community member or a community committee who understand local community conditions and issues.

> *"Home care expertise in the pilot project coordinator helped other staff to find new approaches (problem solving) to meet client needs."*
>
> Shibogama First Nations Council Health Authority

> *"Remove home care from the political arena and use the professional approach. Good leadership who manage well, attract good staff."*
>
> Long Plain First Nation

The planning and development of a home care program was found to be very time intensive. The experience of the pilot sites clearly demonstrated the need for a full time position during the critical planning and implementation period. In addition, the commitment and dedication of the nurse coordinator was identified as key to successful program development.

Two of the pilot sites identified the need for an additional part-time nursing position, in recognition of the fact that the nurse who does the program management and assessments has a very high work load.

High quality staff were found to be essential to the development of the home care program. In order to recruit and retain good staff, some support was found to be essential. The most frequently identified support was the support of the leadership.

> *"Leadership support and their belief in the importance of this program....is critical."*
>
> Champagne and Aishihik First Nations

Working as part of a community-based team was also identified as a very important support to the pilot staff. Good supportive relationships and support from other health and social development staff was considered critical to the program team.

Furthermore, the experiences of the pilot sites demonstrated a need for comprehensive human resource policies and supports, such as a personnel policy manual that is consistently and fairly followed, vacation and sick leave benefits, pension and health benefits, clear job descriptions/expectations and professional supervision and support.

The pilot sites also demonstrated that there is a need to take the time to work with existing community health staff to redefine roles and responsibilities. An expansion of services of this magnitude impacts many other persons working in the community.

There is potential for role confusion and conflict between various staff members if this role clarification is not done in the planning stage. Good communication and inclusion of coworkers in the planning process is therefore critical.

> *"Consultation with others providing health care at all levels from the community up is important to prevent misunderstandings."*
>
> Coordinator
> Champagne and Aishihik
> First Nations

Eel River Bar
First Nation,
New Brunswick

Words of Wisdom

There is a great advantage to having a nurse with home care expertise in the program planning, development and implementation so that new services are developed in new ways.

It is recommended that the program coordinator/ developer be a full time position during the planning and implementation phase. Though the population may vary, the planning time required for a small population is similar to the planning time needed for a larger population.

The home care planning process requires a team approach with support from leadership, other program staff and community members.

Progressive and comprehensive personnel policies are required to support the staff at all levels of service planning and delivery.

Roles of new staff and existing staff must be reviewed in the planning stage to safeguard positive health and social development team relationships.

Training of Home Care Staff

Training of the home support staff was identified as a critical need and some type of training for home care staff was provided in every pilot site. The benefits of this training was seen to be increased self-esteem, job performance and professionalism of staff and improved services. These benefits were found even when the training was not provided under the auspices of a recognized program with certification. However, all communities did attempt to find suitable certified training.

A number of successes were identified regarding the training of home care staff:

- the use of teleconferencing to deliver a course in Little Red River Cree Nation;
- modified course to compensate for language and education level in Shibogama First Nations communities;
- training provided in the community in some sites reduced training costs and allowed the trainees to stay in their home communities, with their families, while they were enrolled in the training program;
- partnering with other communities to provide training programs to reduce costs;
- training resulted in the acquisition of new skills in the community which in turn expanded the capacity to provide in-home meal services, personal care, palliative care, respite services and other home care services.

The evaluation of the Project also identified the following challenges regarding training:

- the difficulty of finding affordable training in the community;
- the lack of certified training for home care staff which addresses English as a second language;
- the difficulty that some potential staff had in meeting educational entrance requirements;
- the critical importance of selecting trainees who are suited for and committed to this type of work;
- the importance of scheduling the initial pre-service training so that trained staff are available at the time of the implementation of the home care program.

Homemakers and Home Support Workers, Wunnumin Lake, Ontario

Words of Wisdom

TRAINING

Training for home care staff is essential for the development of a comprehensive home and community care program.

Training significantly enhances the quality of community-level home care services and the professionalism of staff, promotes the philosophy of independence, and allows a wider number of services to be provided.

POINTS TO CONSIDER FOR TRAINING:

- The instructor should be a registered nurse so that practical experience can be supervised in a long term care facility.
- Certified training that can be built upon for further education is preferred.
- Selection of trainees who are suitable for the work, respected in the community, and who are committed to this type of work, is essential for further successes.
- When education level is a barrier to access certified training, modified training is still beneficial.

Financial Issues

All pilot sites identified needs and plans beyond the funding available. The primary focus of the Project became to establish the foundation for essential services so that the program could expand should additional funds become available in the future. The consolidation of the budgets for the DIAND-funded Adult Care Program (In-Home Component), the First Nations and Inuit Health Branch Building Healthy Communities Home Nursing funding and the Project funding was seen as one way to stretch the service dollars. All northern communities identified the need for additional funding to cover high costs of accommodation, staff wages and travel.

The Project demonstrated that once the basic structure is in place to provide home care services, other services can be readily expanded. For example, one community which already had many of the essential services in place prior to the implementation of the Project was able to greatly expand its service delivery by adding several new components such as a bathing program, meal program, special transportation services, increased nursing services, podiatry, diabetes services and other services.

In summary, the evaluation found a number of successes with respect to the financial aspects of the Project including the integration of the Project funding with the existing home nursing and adult in-home care funding and the general ability to expand the scope and amount of services available in every community.

A number of challenges with respect to Project funding were also identified, including:

- the high cost of air transportation for northern fly-in communities;
- the cost of providing accommodation for nursing staff in remote communities;
- the difficulty of prioritizing needs and deciding on the most needed services;
- the fact that the pilot sites did not know their funding allocation as they were preparing their community service delivery plans;
- delays in receiving funding installments.

Jean D'Or, Little Red River Cree Nation, Alberta

Words of Wisdom

INTEGRATING FUNDING

- ***"Consider integrating Adult Care Program (In-Home component) resources with Home Care resources."*** (Long Plain First Nation leadership)

- ***"Make sure there is funding for a full time Home Care Coordinator Nurse "*** (leadership of Eel River Bar First Nation)

POINTS TO CONSIDER

Identify the home care needs then prioritize the needs in terms of what services will most promote the health and independence of community members.

Develop the supportive structures and implement the most needed services. Future expansion of services will be possible once the foundation is laid and the essential services are in place.

Evaluation meeting. Champagne and Aishihik First Nations

How Home Care Can Make A Difference

Home Care is making a difference in the lives of community members. Though the pilot sites have struggled through the difficult times of creating a new program, the real rewards are in the way that the services impact people's lives.

People who have serious health problems under the age of 65 can now receive home support services. One client stated "***I just wanted to say "thank you" for letting me have someone after I was operated".***

"It is wonderful that the elderly can stay in their home. It gives us more strength to work things out ourselves".

"Laughter is medicine for your sole".

One client received papers to be filled out for long term placement as a result of a short term hospital admission. The Home Care Nurse Coordinator was able to intervene as this was not the wish of the client. Arrangements were made instead for periodic respite rather than long term placement.

One client in his forties suffered a massive stroke. The health staff at the community level used an interdisciplinary approach to facilitate his planning for discharge. The access to equipment, family and staff education, and planning of home based care and support was all arranged so that the client could be transferred back home.

Our home care service offer the elderly and disabled a sense of security and support. As one elder client stated: ***"I have a sense of comfort just knowing I am cared for and belong".***

Respite care provides the care giver with a much needed break – a time where they can plan activities for themselves be it appointments, shopping, or just a time away from day to day care giving responsibilities and duties. As stated by the father of a high needs total care child: ***"Wellness includes not only the physical but the emotional spiritual and mental aspects".***

Parents of a High-Needs Child that require respite care

One band member was believed to be incontinent for years and used depends for years. When the home care client assessment was done it was discovered that the person was not incontinent but that the wheel chair would not fit into the bathroom. A commode and urinal were ordered. The client is now much more independent with his personal care.

One elder was caring for her ailing husband. The Home Care Nurse noticed that the care giver was having some health problems herself. As a result of the nurse's intervention, the elder has now been treated for diabetes and hypertension.

During a client visit, a client stated that she wants to stay in the community. With the help of home care she is able to live in her own home.

First Nations control of the administration of their home care program .... It gives our own people the opportunity to look after the health needs of our own members. Our elders and members can return to their communities in a shorter time period rather than a long hospital stay.

"People return to familiar surroundings sooner and can be visited regularly by their family and friends"

CONCLUSION

The Health Transition Fund Project on First Nations and Inuit Home Care has confirmed the need for new, improved, and/or expanded home care services using as the foundation the essential services identified in the National Home Care Framework. The Project has resulted in a great deal of insightful, practical and valuable information that has provided guidance to Health Canada, and First Nations and Inuit in the development and roll out of the National First Nations and Inuit Home and Community Care Program.

When the pilot teams and leadership from each site were asked what they considered to be the greatest successes of their programs, the following elements were identified:

The use of client assessments to create services based on health needs and to promote independence.

- "***Home Care services are now promoting independence.***" (Shibogama First Nations Council Health Authority)
- "***Care is now based on need.***" (Champagne and Aishihik First Nations)
- "***Home support services are strengthened by basing service on the assessment of need.***" (Eel River Bar First Nation)
- "***Clients have expressed appreciation that their needs are being considered. There have been previously unmet needs discovered and steps taken to address them.***" (Little Red River Cree Nation)

Training of home support staff.

" ***Because there has been training we can provide respite and personal care.*** " (Eel River Bar First Nation)

" ***CAFN Home Care is no longer a house cleaning service but is now based on need and promotes independence.*** " (Champagne and Aishihik First Nations)

The integration of adult in-home care and home care services.

" ***Issues have been brought to light that have not been addressed before. Home Care is advocating for clients and (there is) more coordination of care.*** " (Little Red River Cree Nation)

" ***The services weren't delivered properly before the Project. There has been a big improvement. We (the councilors) receive less complaints now. .....There wasn't enough supervision of the home support staff, it was like a maid service.*** " (Long Plain First Nation)

" ***There is increased accountability of the home support program with the implementation of assessment of need and signed time sheets.*** " (Eel River Bar First Nation)

Expanded health services.

" ***More health services are provided in the client's home now.***" (Little Red River Cree Nation)

" ***Services have been expanded so that palliative care and personal care are now available.***" (Shibogama First Nations Council Health Authority)

Improved coordination of client care.

Home care services for First Nations clients in our area were provided by both the Yukon Territorial Government and Champagne and Aishihik First Nations without any connection between the programs. The goal of the Champagne and Aishihik First Nations Home Care Program is to share those responsibilities for the provision of home care to make the program seamless for the client. (Champagne and Aishihik First Nations)

" ***There is now a single window of entry to home care and continuing care for Long Plain Band members.***" (Long Plain First Nation)

Welcome aboard, Jim Cardinal, Little Red River Cree Nation

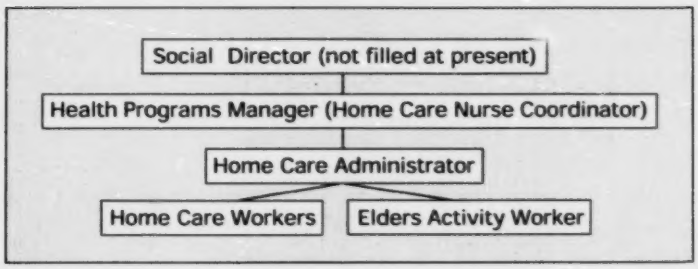
APPENDIX A

DESCRIPTION OF PROGRAM MODELS

Champagne and Aishihik First Nations

Home and Community Care Program Model

Management Structure


Social Director (not filled at present)
Health Programs Manager (Home Care Nurse Coordinator)
Home Care Administrator
Home Care Workers
Elders Activity Worker

Supervision

The Home Care Nurse Coordinator provides professional supervision of all personal care and additional duties assigned to the home care workers. The Home Care Administrator provides the day to day supervision of Home Care Workers.

The Home Care Nurse Coordinator receives peer support from the nurse practitioners employed by the Yukon Territorial Government.

Staffing

- 1 Home Care Nurse Coordinator
- 1 Home Care Administrator
- 1 Full Time Elders Activity Worker
- 1 Part Time Home Care Worker
- 3 casual Relief Home Care Workers
- 2 contract Home Care Workers for outlying communities

Services

Client Assessment

- A formal assessment tool is used by a registered nurse to assess needs of home care clients.
- Client reviews are done according to established policy.
- Services provided are based on health or social needs.

Case Management

- There is now a single point of entry for all home care and long term care clients for Champagne and Aishihik First Nations community members.
- Client advocacy is provided.
- Care is coordinated and managed by the Home Care Nurse Coordinator.
- Initiatives continue to improve discharge planning and communication with Whitehorse General Hospital.

Home Care Nursing

- Home care nursing is provided by the Home Care Nurse Coordinator. Weekend and evenings are covered by the nursing station nurses.

Personal Care

Personal care is provided by trained workers employed by Champagne and Aishihik First Nations in the Haines Junction area. Contract workers will be provided with training as the need and opportunity arises for service in the outlying communities.

Home Support

Home support staff are trained for personal care but also provide homemaking services. Relief contract workers are at present untrained.

Other

Elders activity centre is in the planning stage for weekly activities.

Integration/Coordination and Linkages

Adult Care Program (In-Home Component)

All Home and Community Care and Adult Care (in-home component) is fully integrated financially and administratively.

Community Health

- Nursing staff have regular multi disciplinary meetings.
- The Nurse Practitioners cover weekends and evening for home nursing services.
- Discussions are underway for all health services to be located in the same building.

Outside Health Services

- Monthly meetings with Yukon Territorial Government Home Care Program to coordinate care between the two agencies.
- Discussions have been underway throughout the Project for the full integration of home care services for Haines Junction for both band members and non band members to eliminate duplication of service. This has been a time consuming process and there has been three levels of government and two departments of the Territorial government to deal with. These meetings have had limited success at the middle manager level. It is likely now to enter the political arena.
- Contact will be made to work with Whitehorse General Hospital to improve discharge planning.

Infrastructure

The following infrastructure were identified in the pilot site as important for the development of a Home and Community Care Program.

Training:

- Training for home support staff. Nine (9) Home Care Workers trained through the Project. In retrospect the community would have waited until the program was ready for service delivery before training the workers, and would have used an accredited college so that the course could be used for further training.

- Conflict resolution workshop
- Safe care of clients including lifts and transfers
- Safe food handling training
- CPR re-certification
- Conflict resolution and managing difficult people
- Regular ongoing in service for all staff
- Each staff has developed a learning plan

Supportive Structures:

- Job shadowing with Territorial Home Care
- Program policies
- Pay equity with other employees working in the same area
- Liability insurance
- Policy and procedure manual
- Performance appraisals
- Work descriptions
- Personnel policies
- Assessment tool
- Monthly reports

Equipment and Supplies:

- Nursing equipment and bag
- Nursing supplies for provision of client care

Capital:

- Van purchased for health staff
- Computer, printer and software

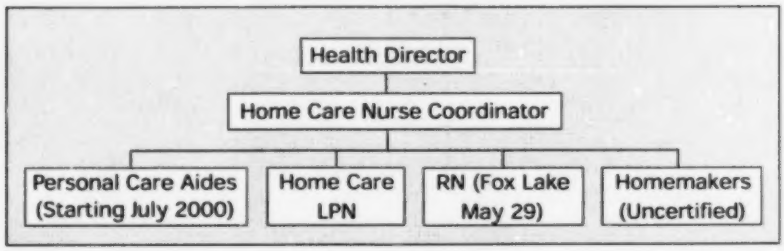
Note:

The Home Care Plan identified need for satellite telephones. These have not been found to be useful in relation to the cost, and the lease is being cancelled.

Little Red River Cree Nation

Home and Community Care Program Model

Management Structure



At the time of the site visit the home care nurse had just been hired, and the Adult Care services were not yet integrated. This integration is planned for May 2000. Leadership has approved a plan for full integration of all health and social services.

Supervision

The Health Director oversees the Home and Community Care Program. Professional supervision is provided through the First Nations and Inuit Health Branch at this time for the Home Care Nursing. The Home Care Nurse Coordinator will provide direct supervision to the personal care aides, homemakers, the Licenced Practical Nurse, and Home Care Nurse for Fox Lake.

Staffing

- 1 Full Time Home Care Nurse Coordinator
- 1 Full Time Licenced Practical Nurse
- 11 homemakers in training - (4 to serve in Fox Lake) will be full time when training is complete

Existing workers who have not taken training will be able to work casual while upgrading their skills.

Plan to integrate with Home and Community Care May 2000

Home Care Nurse for Fox Lake to start end of May 2000.

Services

Client Assessment

All home care clients have received assessments of home care needs, and some have received the three month follow up visit. An assessment tool has been developed. Revision to the tool is planned.

Care is needs based.

Case Management

The newly hired Home Care Nurse Coordinator will do the case management for all home care clients.

Home Care Nursing

Home Care Nurse Coordinator will provide home nursing based on policies in place.

Personal Care

Personal care will be available after the Personal Care Aides complete their training in June 2000.

Home Support

Home support available at present and will soon be fully integrated with Home and Community Care.

Other

Foot care is provided for frail elderly and persons with diabetes.

Integration/Coordination and Linkages

Adult Care Program

Full integration of budget and program management of the Adult Care Program and the Home and Community Care program is in place for immediate implementation. The community has also developed a plan for full integration of health and social services.

Community Health

The community health staff are employed by the First Nations and Inuit Health Branch, but both programs are housed out of the same office. There have been several meetings and discussions throughout the Project to define roles and responsibilities. These will continue as the services are implemented.

- Monthly meeting held for home care and community health staff
- FNIHB support - monthly meetings held during the Project.

Outside Health Services

- Discharge planning linkages still need to be improved.
- Meetings are being held with regional health authorities. The newly hired Home Care Nurse Coordinator has linkages with the local health district.

Infrastructure

The following infrastructure was identified in the Project as important for the development of a Home and Community Care Program:

Training:

- Home care aide training
- Foot Care training for RN's and Home Health Aides
- in service's for home care staff, ie, CPR, WHIMIS

Supportive Structures:

- Vision and Philosophy
- Program policies
- Job descriptions
- Liability insurance
- Charting system and client files
- Personal policies
- Staff benefits
- Record of services provided to clients

Equipment and Supplies:

- Nursing equipment and bag
- Furniture: desk and file cabinet
- Supplies such as dressing supplies
- Vehicles for nurses
- Storage
- Laundry of clients
- Need for better telecommunication systems to communicate with nurses travelling, no cell phones, no paging and clients often have no phones.

Capital:

- Office space for staff
- Accommodation for nursing staff.

Long Plain First Nation

Home and Community Care Program Model

Long Plain First Nation had many of the core elements in place prior to the Project. With the support and funding from the Project, they took the opportunity of strengthening their existing services by reinforcing the foundational infrastructure then expanding services.

The program was first strengthened by developing the program vision and philosophy, which was supported by the community, staff and leadership.

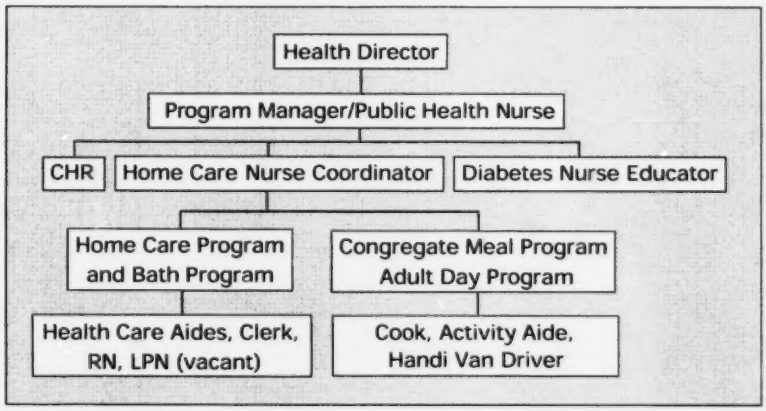
The next steps were to:

- train existing staff so that they could perform personal care and meal preparation
- develop program policies, procedures
- develop a client file
- start client assessments so that services provided are based on need

When the essential services were strengthened, the team expanded the services to include:

- a bathing program with a Century tub in a central location
- handi bus transportation
- congregate meal program
- adult day program with a diabetes education and activity component

Management Structure


Health Director
Program Manager/Public Health Nurse
CHR
Home Care Nurse Coordinator
Diabetes Nurse Educator
Home Care Program and Bath Program
Congregate Meal Program Adult Day Program
Health Care Aides, Clerk, RN, LPN (vacant)
Cook, Activity Aide, Handi Van Driver

Supervision

The Home Care Nurse Coordinator supervises the home care staff. She receives professional and day to day supervision from the Health Program Manager.

Staffing

- 1 Home Care Nurse Coordinator
- 1 Licenced Practical Nurse (not filled)
- 1 Casual Registered Nurse
- 2 Full Time and 2 Part Time Health Care Aides, 2 Casual Health Care Aides
- 1 Part Time Cook
- 1 Part Time Activity Aide
- 1 Full Time Driver (Handi Van)
- 1 Full Time Clerk
- 1 Part Time Diabetes Nurse Educator

Services

Client Assessment

- All referrals receive initial assessment of need by a registered nurse who then determines if home care services are required.
- An assesment tool is used to provide a complete assessment.
- A Care Plan is prepared for every client.
- Reviews of services are scheduled for every three months.

Case Management

The Home Care Nurse Coordinator manages the care for all clients.

Home Care Nursing

Minimal home care nursing is presently available due to workload of Home Care Nurse Coordinator. Presently we are recruiting a Home Care Nurse.

Personal Care

Personal care is available. The Health Care Aides are trained and supervised in the provision of personal care.

Home Support

Home support services are available based on the assessed need. Health Care Aides are supervised and assigned tasks.

In-Home Respite

Available based on the assessed need.

Palliative Care

Available based on assessed need.

Other

- Monthly shopping program available as part of the Adult Activity Program.
- Therapeutic Bath Program.
- Handicapped transportation available.
- Adult Day Program for people with diabetes and/or people with chronic conditions.
- Meal Program, operating 3 days/week plus meal delivery available according to assessed need.
- Life Line (Emergency Response System incorporated into high risk client homes).

Integration/Coordination and Linkages

Adult Care Program

The DIAND Adult In-Home Care Program is fully integrated with the Home Care Program. All staff are paid, supervised and assigned work through the Home and Community Care Coordinator.

Community Health

The community health staff work closely with the Home Care Program. The Program Manager/Public Health Nurse provides supervision of the Home Care Coordinator, and has actively participated in the planning of the Home and Community Care Program. The nursing roles are clearly defined. The Diabetes Nurse Educator and CHR work with both programs.

Outside Health Services

- Linkages have been established for discharge planning.
- Linkages have been established with outside health care facilities for in-service opportunities for the home and community care staff.

Infrastructure

The following infrastructure was identified in the Project as important for the development of a Home and Community Care Program.

Training:

- Certified training for Home Care Aides (9 graduated from training)
- Food Handling course
- CPR training
- Foot Care in service for nurses (provided by a podiatrist)
- Continuing Education.

Equipment:

- DCA 2000 which tests HbgA1c, and microalbuminuria
- Handi Van
- Nursing equipment and supplies
- Medical equipment to assist client with independent living.

Supportive Structures:

- Program policies and guidelines
- Assessment tool
- Client records which are in use for all home care clients
- Increment and benefit package for Home Care Staff
- Revised and improved Personnel policy
- Guidelines for the congregate meal, adult day, and therapeutic bath programs have been developed
- Orientation package for new staff
- Discharge protocols complete with forms
- A home care contract amongst the home care coordinator, client and primary caregiver
- Monthly newsletters to maintain communication in the community
- Pamphlets for public education and promotion of programs.

Shibogama First Nations Council
Health Authority

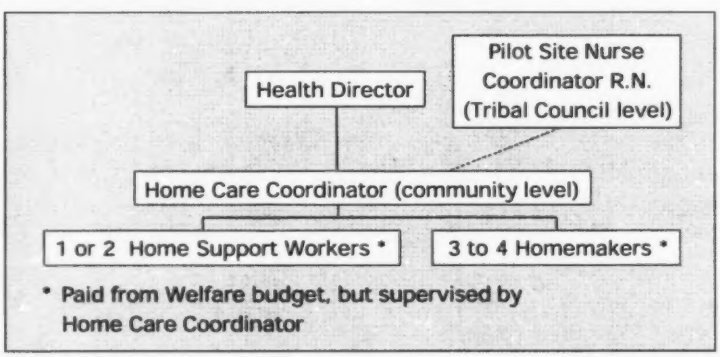
Home and Community Care Program Model

One of the tasks of the Project was to establish a home care program that would respond to the unique social, cultural and geographical conditions of the community. The philosophy of the Shibogama Council is to provide assistance for the bands to set up the community based programs. Through the Project a Home Care Project Coordinator was contracted at the Tribal Council level to provide expert support and guidance with planning and implementation at the community level. The Tribal Council role diminishes as the community is ready to administer the program. The Shibogama First Nations Council responded by developing the following program model and services.

Management Structure

The Shibogama bands have three separate programs under the direction of the Chief and Council and directed by the Health Director. During the Project the Tribal Council played a coordinating role in the set up and development of the programs and providing expert support.

This management structure is for each of the three communities:


Health Director
Pilot Site Nurse Coordinator R.N. (Tribal Council level)
Home Care Coordinator (community level)
1 or 2 Home Support Workers *
3 to 4 Homemakers *
* Paid from Welfare budget, but supervised by Home Care Coordinator

The Home Care Coordinators are community based staff who are not required to have a professional health background. They must however speak Oji-Cree and live in the community.

Supervision

- The Health Director (in 2 communities) and Social Services Director (in 1 community) is the direct supervisor of the Home Care Coordinators at the community level.
- Homemakers and home support staff are supervised by the Home Care Coordinators.
- Professional supervision for Home Support staff providing personal care has been through the instructor (RN) or the Pilot Site Nurse Coordinator at the Tribal Council. How the professional supervision will be provided at the end of the Project is still under discussion.

Staffing

- 1 Pilot Site Nurse Coordinator (on contract for all three bands)
- 3 Full Time Home Care Coordinators (one in each community) who speaks Oji-Cree and lives in the community
- 3 or 4 Homemakers for household tasks and personal care in each community
- 1 to 2 Home Support Workers for each community (who do heavy work)

Services

Client Assessment

- Formal assessment of needs for home support and personal care. Most community members do not read/speak English, so conversion of assessment tool is difficult.
- During the Project a nurse and the Pilot Site Nurse Coordinator conducted the client assessments. After the Project is complete the coordinators will do the assessments with help from the community nurse.
- Some assessment training has been done with the Home Care Coordinators.

Case Management

- Home support and personal care are coordinated at the community level.
- Case management through the Project was provided by the Pilot Site Nurse Coordinator.

Home Care Nursing

Lack of resources, accommodation and difficulty with staff recruitment prevented the home nursing component from being developed. This remains a longer term goal. A Health Director stated that the home care nurse will have a focus on wellness and health promotion.

Personal Care

Personal care is available by trained workers (when the training is complete in all communities). To date the personal care has been professionally supervised by the instructor or the Pilot Site Nurse Coordinator, both of which are registered nurses. How this will be supervised after the Project ends is under discussion.

Home Support

- Homemaking services are now based on need rather than financial status.
- All who have an assessed need for homemaker or home support services or personal care can receive care. The Home Support Workers provide heavy assistance with wood cutting and water hauling. The Homemaker workers provide home making and personal care.

Integration/Coordination and Linkages

Adult Care Program

Complex funding arrangements with the Ontario Government made it difficult to integrate the Adult Care Program funding with the Home Care Project funding, however the program supervision and direction has been integrated with the Home and Community Care Program.

Community Health

- The Home Care Coordinators have offices in the nursing station (in two of the communities), and they now have regular discussions regarding client concerns.
- The nursing station nurse interviewed has noticed an increased skill in the home support staff's ability to make appropriate referrals.
- Another example of linkage: The home care staff involved in caring for a palliative client who died in the home were debriefed along with the family.

Outside Health Services

- All linkages with off reserve facilities are through the nursing station.
- There have been increased linkages with off reserve rehabilitation services.
- Future plans to improve hospital discharge planning services.

The Community

Each of the communities of the Shibogama First Nations Council are isolated and can only be reached by air travel. The Home Care Coordinators have initiated a monthly conference call as a forum to communicate.

One of the ways that information about home care was communicated to the community was by using the local community radio station. The home care coordinators went on the radio, spoke in the community's language first, then answered the phone-in questions.

Infrastructure

The following infrastructure was identified in the Project as important for the development of a Home and Community Care Program:

Training:

- Training for homemakers, coordinators and home support staff.
  A non-certified 120 hour curriculum was modified and delivered in the community settings. One of the communities was running the program at the time of the site visit.
- Occupational therapy training session in one community.

Supportive Structures:

- Home Care expertise
- Simplified report forms
- Orientation checklist for coordinators
- Orientation guidebook for coordinators and workers
- Job descriptions
- Policy manual (in draft form)
- Planned monthly report forms by community Home Care Coordinators to send to leadership which includes statistics and trends of care needs.

Equipment and Supplies:

- An equipment loan cupboard was established
- Nursing bag for the nursing station nurses to use for home visits
- Air transportation to and between communities required.

Capital:

- Accommodation for visiting home care personnel
- Computer equipment
- Office space at each community for home care coordinator

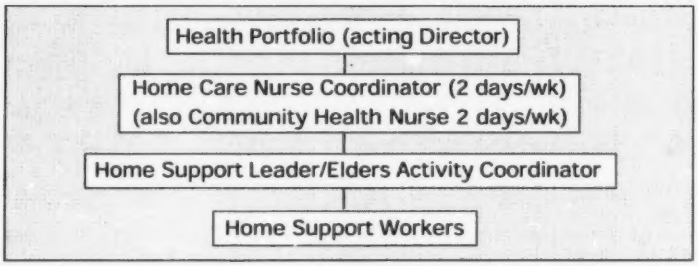
  and The Training which was done in the community.handy-causedirto

Eel River Bar First Nation

Home and Community Care Program Model

Eel River Bar First Nation already had most home care services in place from different off reserve agencies. They saw no need in duplicating existing services. The focus therefore of the Project has been to develop training and supportive structures to improve the adult care program and coordination of services.

Management Structure


Health Portfolio (acting Director)
Home Care Nurse Coordinator (2 days/wk)
(also Community Health Nurse 2 days/wk)
Home Support Leader/Elders Activity Coordinator
Home Support Workers

The Home Support Leader has transferred from the Child and Family Services Program. The position changed from part time to full time and now supervises the Home Care Workers and functions as an Elders Activity Coordinator.

Supervision

It has not yet been decided who will provide professional support for the Home Care Nurse Coordinator. One option being considered is the Regional Home Care Coordinator with the First Nations and Inuit Health Branch.

The Home Care Coordinator in Eel River Bar First Nation supervises the Home Support Leader and provides professional supervision to the Home Support Workers for personal care.

The Home Support Leader provides day to day supervision to the Home Support Workers, both new and existing, trained and untrained workers.

Staffing

- 1 Part Time Home Care Nurse Coordinator
- 1 Full Time Home Support Leader
- 11 Part Time and Casual Home Care Workers including family members and trained workers
- Advertising for dietitian 1 day per week. (Because small population of 383 makes it difficult to stretch funding, the Band is considering working with another Band to provide dietitian services.)

Services

Client Assessment

Service is no longer based on age or financial status. Now all persons in need can qualify for home care services.

New Clients

- Service to new clients based on need
- Trained workers provide the service.

Existing Clients

- No changes to care of previous clients as yet
- Trained workers provide personal care
- All clients have received assessments
- No changes to care until fully supported by Chief and Council
- Assessment Review Committee established to review the client assessments and decide on the hours of need.

Case Management

- Case management for all extramural services is managed by the New Brunswick Extramural Hospital Program.
- On reserve home support services are case managed by the Community Health Nurse/Home Care Coordinator.

Home Care Nursing

- Home nursing is provided by the New Brunswick Extramural Hospital Program and is an insured service for all residents of New Brunswick. It is available 24 hrs a day, 7 days a week.

Personal Care

- All new clients receive care by trained workers
- No change at this time for those clients currently receiving care from paid family members.

Home Support

- Eel River Bar First Nation responded by taking a very cautious approach to implementing changes to the Adult Care Program until written assurances of funding and funding amounts received for post pilot period.

In-Home Respite

- Available through trained workers, or paid family members for existing clients.

Other

- Elders meal every two weeks
- Elders activities gatherings being planned.

Integration/Coordination and Linkages

Adult Care Program

The Adult Care Program was initially administered under the Child and Family Services. It is now fully integrated with the Home Care program for program management, supervision and budget. There has been joint planning with Child and Family Services throughout the Project and the Director continues to sit on the Assessment Review Committee. A community Elder also sits on the Assessment Review Committee.

Community Health

This linkage is very close as the Community Health Nurse and Home Care Nurse is the same person. The Community Health Nurse was working two days per week before the Project. The Project increased her time by two days per week. Playing dual roles has caused some difficulties in time management and getting the required work done.

Outside Health Services

- Initial contact has been made to improve communication linkages between the Hospital and the New Brunswick Extramural Hospital Program and the Reserve based health services.
- A pamphlet and referral form have been developed will be distributed once they are printed.
- Linkages need to be improved with Non Insured Health Benefits so a doctor's order is not required for activity aides.

Infrastructure

The following infrastructure was identified in the pilot site as important for the development of a Home and Community Care Program.

Training:

- 9 homemakers completed an 8 week training course
- Identified need for further training for home support workers
- foot care training for Home Care Nurse planned for future.

Supportive Structures:

- draft policy manual -- pending approval of the leadership
- appeal process to address conflict in client assessment and coordination
- orientation plan
- job descriptions
- referral form developed
- client files
- time sheets to increase accountability
- monthly reports, narrative and statistics
- quarterly summary reports
- pamphlet – promote public awareness.

Equipment and Supplies:

- foot care instruments
- office supplies
- printing costs.

Capital:

- computer and printer
- desk
- office space.